MINNESOTA HEALTH CARE QUALITY REPORT

PART 3: TOP PERFORMING MEDICAL GROUPS ACROSS ALL QUALITY MEASURES

Results for care delivered in 2022 | Report released January 2024

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ABOUT MN COMMUNITY MEASUREMENT

As an independent nonprofit dedicated to empowering health care decision makers with meaningful data, MN Community Measurement (MNCM) is a statewide resource for timely, comparable information on health care quality, costs, and equity. While Minnesota has some of the best health indicators in the country, there continues to be wide variation in health care quality and wide disparities in outcomes for different population groups. Measuring and reporting on health care quality helps consumers understand how care varies across providers, allows providers to identify improvement opportunities and how their quality results compare to others, and helps health plans and other purchasers better understand and improve value for the money that is spent on health care.

ABOUT THIS REPORT

MN Community Measurement's *Health Care Quality Report* will be released in three parts:

- **Part 1:** Clinical quality measures reported by medical groups
- **Part 2:** Clinical quality measures reported by health plans
- **Part 3:** Top performing medical groups across all quality measures (this report)

This report summarizes the top performing medical groups across all clinical quality measures for the 2022 measurement year. New to the report this year is a summary of the Total Cost of Care for the top performing medical groups.

ADDITIONAL RESOURCES

- Medical group and clinic performance rates can be found here: https://mncm.org/appendix-tables/
- Medical group and clinic profile pages can be found here: https://mncm.org/mnhealthscores/
- The Cost & Utilization report can be found here: https://mncm.org/reports/#community-reports

ACKNOWLEDGEMENTS

This report is made possible by the engagement of numerous stakeholders, including medical groups, payers and MNCM's Data Validation and Data Analysis teams. Each are committed to continuous improvement and recognize the important role measurement plays in helping our community establish priorities and improve together.

MNCM extends our thanks to all medical groups and payers for contributing the data necessary for measurement, to the State of Minnesota for its support through the Statewide Quality Reporting and Measurement System and to the many members of MNCM committees, workgroups and staff providing ongoing guidance to shape this important work.

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TOP PERFORMERS ACROSS ALL CLINICAL QUALITY MEASURES

2022 measurement year

QUALITY MEASURE			Central Pediatrics	Essentia Health	Health Partners Clinics	Mankato Clinic, Ltd.	Mayo Clinic	Park Nicollet Health Services	South Lake Pediatrics
REPORTED BY MEDICAL GROUPS DDS/PIPE	ADULTS	Colorectal Cancer Screening	-	●	○	●	○	●	-
		Optimal Asthma Control	●	●	●	●	○	●	●
		Optimal Diabetes Care	-	●	●	●	●	●	-
		Optimal Vascular Care	-	●	●	○	○	●	-
		Depression: Follow-up PHQ-9 at 12 Months	○	●	●	●	●	●	○
		Depression: Remission at 12 Months	○	●	●	○	●	●	○
	CHILDREN/ ADOLESCENTS	Adolescent Mental Health and/or Depression Screening	●	●	○	●	●	○	●
		Optimal Asthma Control	●	●	●	●	○	●	●
		Depression: Follow-up PHQ-9 at 12 Months	○	●	●	●	●	●	○
		Depression: Remission at 12 Months	○	●	○	○	●	●	○
REPORTED BY PAYERS HEDIS	PREVENTIVE HEALTH	Breast Cancer Screening	-	●	●	●	●	●	-
		Cervical Cancer Screening	<	○	●	○	○	○	<
		Childhood Immunization Status (Combo 10)	●	○	○	○	○	○	●
		Chlamydia Screening in Women	●	○	●	○	○	●	○
		Immunizations for Adolescents (Combo 2)	○	○	○	○	●	●	○
	ACUTE & CHRONIC CONDITIONS	Avoidance of Antibiotic Treatment in Acute Bronchitis/Bronchiolitis	●	○	●	●	●	●	●
		Controlling High Blood Pressure	<	○	○	○	●	○	<
		Diabetes Eye Exam	<	●	●	●	○	●	<
		Follow-up Care for Children Prescribed ADHD Medication	○	○	○	○	○	●	●
		Osteoporosis Management in Women who had a Fracture	-	○	○	<	●	○	-
		Use of Spirometry Testing in the Assessment and Diagnosis of COPD	-	○	●	○	●	●	-
TOTAL MEASURES ABOVE STATEWIDE AVERAGE			6	12	13	10	12	16	6
TOTAL ELIGIBLE MEASURES			12	21	21	20	21	21	12
% OF MEASURES ABOVE STATEWIDE AVERAGE			50.0%	57.1%	61.9%	50.0%	57.1%	76.2%	50.0%

There were seven medical groups that scored significantly above the statewide average on at least 50% of the measures for which they were eligible.*

Detailed results by medical group and clinic are available in MNCM's Appendix Tables, which can be found here: https://mncm.org/appendix-tables/.

*Included if eligible for at least five measures.

● Above Average

○ Below Average or Average

< Not reportable (too few patients for measure)

- Not assigned to measure

TOTAL COST OF CARE FOR MEDICAL GROUPS THAT WERE TOP PERFORMERS ON QUALITY

2022 measurement year

MEDICAL GROUP	TOTAL COST OF CARE POPULATION		
	Overall	Adults	Pediatric
Central Pediatrics	●	○	●
Essentia Health – Central Region	○	○	○
Essentia Health – East Region	○	○	○
Essentia Health – West	○	○	●
HealthPartners Clinics	●	●	○
Mankato Clinic, Ltd.	○	○	○
Mayo Clinic	○	○	○
Park Nicollet Health Services	●	●	○
South Lake Pediatrics	●	○	●

Of the seven medical groups identified as top performers:

- Four had lower than average costs for the overall population.
- Two had lower than average costs for the adult population.
- Three had lower than average costs for the pediatric population.

● Lower than Average Cost

○ Higher than Average or Average Cost

Note: Essentia Health is split into three regions for total cost of care reporting.

METHODOLOGY

Measure definitions can be found in Parts 1 & 2 of the Health Care Quality Report series

SUMMARY OF QUALITY MEASURE TYPES

	QUALITY MEASURE	PROCESS	OUTCOME	PRO-PM	COMPOSITE	HYBRID	ADMIN
REPORTED BY MEDICAL GROUPS DDS/PIPE	Colorectal Cancer Screening	●					
	Optimal Asthma Control *(Adults & Children)*		●	●	●		
	Optimal Diabetes Care		●		●		
	Optimal Vascular Care		●		●		
	Depression: Follow-up PHQ-9 at 12 Months *(Adults & Adolescents)*	●					
	Depression: Remission at 12 Months *(Adults & Adolescents)*		●	●			
	Adolescent Mental Health and/or Depression Screening	●					
REPORTED BY PAYERS HEDIS	Breast Cancer Screening	●					●
	Cervical Cancer Screening	●				●	
	Childhood Immunization Status (Combo 10)	●				●	
	Chlamydia Screening in Women	●					●
	Immunizations for Adolescents (Combo 2)	●				●	
	Avoidance of Antibiotic Treatment in Acute Bronchitis/Bronchiolitis	●					●
	Controlling High Blood Pressure		●			●	
	Diabetes Eye Exam	●					●
	Follow-up Care for Children Prescribed ADHD Medication	●					●
	Osteoporosis Management in Women who had a Fracture	●					●
	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	●					●

Composite measures: A measure of two or more component measures, each of which individually reflects quality of care, combined into a single performance measure with a single score. The individual components are treated equally (not weighted). Every component must meet criteria to be counted in the numerator for the overall composite measure.

Outcome measures: These measures reflect the actual results of care. They are generally the most relevant measures for patients and the measures that providers most want to change.

Patient-reported outcome measures (PROM): A validated survey instrument or tool used to collect information directly from a patient.

Patient-reported outcome performance measures (PRO-PM): The measure built from a PROM.

Process measures: A measure that shows whether steps proven to benefit patients are being used. They measure whether an action was completed (e.g., having a medical exam or test, writing a prescription or administering a drug).

Hybrid measures: These measures use health plan claims data and medical record review data to identify patients who are eligible for the measure.

Admin measures: These measures use health plan claims data to identify patients who are eligible for the measure.

METHODS

The measures in this report are collected from two separate data sources: medical groups and payers. Measures that are reported by medical groups enable reporting of results by clinic location as well las by medical group. In contrast, the Healthcare Effectiveness Data and Information Set (HEDIS) measures used data reported by payers. This data enables reporting of results by medical group only. The methods of each data source are described below. Following the Methods section is a table that shows the number of patients included in each measure from 2020 to 2022.

MEASURES REPORTED BY MEDICAL GROUPS

DATA COLLECTION

MNCM is in the midst of transitioning its data collection for the clinical quality measures reported by medical groups to a modernized system known as PIPE that reduce quality measurement burden on health care providers and enables more timely feedback on performance. The previous data collection system, known as Direct Data Submission or DDS, required providers to separately identify the relevant population for each measure. The new PIPE system identifies the numerators, denominators, and performance rates for each measure centrally. About 53 percent of the data reported to MNCM for the clinical quality measures for Measurement Year 2022 was submitted via PIPE, and the transition to the new system is expected to be complete by the 2024.

CONFIDENCE INTERVALS

Due to the dynamic nature of patient populations, rates and 95 percent confidence intervals are calculated for each measure for each medical group/clinic regardless of whether the full population or a sample is submitted. The statewide average rate is displayed when comparing a single medical group/clinic to the performance of all medical groups/clinics to provide context. The statewide average is calculated using all data submitted to MNCM which may include some data from clinics located in neighboring states.

MEDICAL GROUP AND CLINIC LEVEL RESULTS

Medical group and clinic level results and ratings for the 2022 measurement year can be found via MNCM's Appendix Tables, which can be accessed here.

THRESHOLD FOR PUBLIC REPORTING

MNCM has established minimum thresholds for public reporting of clinical quality measures reported by medical groups to ensure statistically reliable rates. Only medical groups and clinics that meet the threshold of 30 patients in the denominator of a measure are publicly reported.

RISK ADJUSTMENT

Risk adjustment is a technique used to enable fair comparisons of clinics/medical groups by adjusting for the differences in risk among specific patient groups. It is especially important for outcome measures that are influenced by factors outside of the control of health care providers. MNCM uses an "Actual to Expected" methodology for risk adjustment. This methodology does not alter a clinic/medical group's result as the actual rate remains unchanged. Instead, each clinic/medical group's rate is compared to an "expected rate" for that clinic/medical group based on the specific characteristics of patients seen by the clinic/medical group, compared to the total patient population.

MEASURES REPORTED BY MEDICAL GROUPS

RISK ADJUSTMENT CONTINUED

All expected values for clinical quality measures reported by medical groups are calculated using a logistic regression model including the following variables:

Measure	Risk Adjustment Variables
Colorectal Cancer Screening	Insurance product, deprivation index, patient age
Optimal Asthma Control	Insurance product, deprivation index
Optimal Diabetes Care	Insurance product, deprivation index, patient age, diabetes type
Optimal Vascular Care	Insurance product, deprivation index, patient age
Depression Care Suite	Insurance product, deprivation index, patient age, depression severity

Insurance product type includes commercial, Medicare, Medicaid, uninsured, unknown.

The **deprivation index** was added in 2018 and includes ZIP code level average of poverty, public assistance, unemployment, single female with child(ren), and food stamps (SNAP) converted to a single index that is a proxy for overall socioeconomic status.

A Chi-square test is used to determine whether there is a statistically significant difference between the expected and actual rates of optimally managed patients attributed to each clinic/medical group. The methodology uses a 95 percent test of significance.

Measures that are not risk adjusted include: Adolescent Mental Health and/or Depression Screening and the PHQ-9/9M Utilization measures. This is because these are process measures that are not generally influenced by factors outside of a health care provider's control.

MEASURES REPORTED BY PAYERS

DATA COLLECTION

Administrative Method: These HEDIS measures use payer claims data to identify the patients who are eligible for the measure (denominator) and for the numerator.

- Breast Cancer Screening
- Chlamydia Screening in Women
- Diabetes Eye Exam
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Avoidance of Antibiotic Treatment in Acute Bronchitis/Bronchiolitis
- Follow-up Care for Children Prescribed ADHD Medication
- Osteoporosis Management in Women Who Had a Fracture

MEASURES REPORTED BY PAYERS

DATA COLLECTION CONTINUED

Administrative method: These HEDIS measures use payer claims data to identify the patients who are eligible for the measure (denominator) and for the numerator.

- Breast Cancer Screening
- Chlamydia Screening in Women
- Diabetes Eye Exam
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Avoidance of Antibiotic Treatment in Acute Bronchitis/Bronchiolitis
- Follow-up Care for Children Prescribed ADHD Medication
- Osteoporosis Management in Women Who Had a Fracture

Hybrid method: These HEDIS measures use payer claims data to identify the patients who are eligible for the measures. Numerator information comes from payer claims and medical record review data. Because medical record review data is costly and time-consuming to collect, payers select a random sample from the eligible patients to identify the measure denominator. For the immunization measures, payers also use data from the Minnesota Immunization Information Connection (MIIC).

- Cervical Cancer Screening
- Childhood Immunization Status (Combo 10)
- Immunizations for Adolescents (Combo 2)
- Controlling High Blood Pressure

Continuous enrollment criteria: The minimum amount of time for a member/patient to be enrolled in a payer to be eligible for a HEDIS measure. It ensures the payer has enough time to render services. If a member/patient does not meet minimum continuous enrollment criteria, they are not eligible to be included in the measure denominator.

ELIGIBLE POPULATION SPECIFICATIONS

The eligible populations for the administrative and hybrid measures are identified by each participating payer using its respective administrative claims database. Payers assign patients to a medical group using a standard medical group definition based on a tax identification number (TIN). Administrative billing codes determine the frequency of a patient's visits to a medical group. For most measures, patients are assigned to the medical group they visited most frequently during the measurement period. Patients who visited two or more medical groups with the same frequency are attributed to the medical group visited most recently in the measurement period. The TIN is used as the common identifier for aggregating data across payers.

CALCULATING RATES

HEDIS administrative and hybrid measures are reported at a medical group level and are expressed as percentages. Rates calculated for hybrid measures require weighting because of the sampling procedures applied. Rates and 95-percent asymmetrical confidence intervals are calculated for each measure for each medical group (Asymmetrical confidence intervals are used to avoid confidence interval lower bound values less than zero and upper bound values greater than one hundred). The medical group overall average is used to compare to the individual medical group's rate for the performance ratings. The statewide average includes attributed and unattributed patients.

The HEDIS measures included in this report are not risk adjusted.

MEASURES REPORTED BY PAYERS

THRESHOLDS FOR PUBLIC REPORTING

MNCM has established minimum thresholds for HEDIS public reporting to ensure statistically reliable rates. Only medical groups that meet the thresholds of 30 patients in the denominator of HEDIS administrative measures and 60 patients in the denominator of HEDIS hybrid measures are publicly reported.

LIMITATIONS

Patients who are uninsured, self-pay, served by Medicaid/Medicare fee-for-service, or insured by payers not participating in MNCM data collection are not reflected in the HEDIS results.

PAYERS CONTRIBUTING DATA

- Blue Cross Blue Shield of MN
- HealthPartners
- Hennepin Health
- Itasca Medical Care
- Medica
- Preferred One
- PrimeWest Health
- Sanford Health
- South Country Health Alliance
- UCare

TOTAL COST OF CARE MEASURES

The Total Cost of Care measure is calculated for patients with commercial health insurance using information calculated from claims by four health plans. For more details on the methodology, see the Health Care Cost & Utilization in 2022 report.

NUMBER OF PATIENTS INCLUDED IN QUALITY MEASURES

MEASURES REPORTED BY MEDICAL GROUPS

2022 measurement year

QUALITY MEASURE	Age Range	Number of Patients in Denominator
Adolescent Mental Health and/or Depression Screening	12-17	158,741
Colorectal Cancer Screening	45-75^	1,565,854*
Adolescent Depression Measure Suite	12-17	16,587
Adolescent PHQ-9/9M Utilization	12-17	14,893
Adult Depression Measure Suite	18+	113,762
Adult PHQ-9/9M Utilization	18+	196,817
Optimal Asthma Control – Adults	18-50	143,631*
Optimal Asthma Control – Children	5-17	59,469*
Optimal Diabetes Care	18-75	325,697
Optimal Vascular Care	18-75	184,417

The measures in this report are collected from clinics and enables reporting by clinic location and medical group

This table shows the number of patients included in each measure by measurement year.

Some measures allow for medical groups to submit a sample of their eligible population. The numbers provided in the table represent the actual number of patients submitted for the measure. Denominators that include samples are denoted with an asterisk (*).

NOTE: The COVID-19 pandemic affected many aspects of health care, including care delivery and access. Since the measures apply to those who accessed care, fewer people were included in the measure denominators in 2020 as a result.

^Age range changed in 2022MY from 50-75 to 45-75

NUMBER OF PATIENTS INCLUDED IN QUALITY MEASURES

MEASURES REPORTED BY PAYERS

2022 measurement year

QUALITY MEASURE	Age Range	Number of Eligible Patients	Number of Patients in Denominator
Avoidance of Antibiotic Treatment in Acute Bronchitis/Bronchiolitis	3 months and older	26,240	26,240
Breast Cancer Screening	50-74	345,482	345,482
Cervical Cancer Screening*	21-64	682,211	13,603
Childhood Immunization Status (Combo 10)*	2 years	39,626	6,521
Chlamydia Screening in Women	16-24	109,284	109,284
Controlling High Blood Pressure*	18-85	328,665	20,042
Diabetes Eye Exam	18-75	182,018	182,018
Follow-up Care for Children Prescribed ADHD Medication	6-12	8,690	8,690
Immunizations for Adolescents (Combo 2)*	By age 13	48,380	6,476
Osteoporosis Management in Women who had a Fracture	67-85	2,431	2,431
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	40 years and older	11,577	11,577

This table shows the number of patients included in each measure for measures reported by payers.

Hybrid measures use a random sample of the eligible population. These measures are denoted with an asterisk (*).

Hybrid measures include data from both claims and medical charts, and non-hybrid measures include data from only claims.